



## Authorization for the Release of Protected Health Information

Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

I authorize the following Protected Health Information to be disclosed (Select all that applies):

- My claim information:
  - All dates of service
  - The following dates of services \_\_\_\_\_
- Dependant(s) claim information (Name the dependant(s)): \_\_\_\_\_
  - All dates of service
  - The following dates of services \_\_\_\_\_
- Financial Information.
- Plan or benefit coverage information.
- Appeal status or information.
- Any other information regarding my account and/or dependant(s).

I authorize Dominion Dental Services, Inc. and Dominion Dental Services USA, Inc. to release the Protected Health Information explained above to the following entity. I understand that if this person or organization is not a health plan or other entity subject to federal privacy laws, they may further disclose my information and the information may no longer be protected by federal privacy laws.

Name of Organization or Individual: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

This authorization will automatically expire on \_\_\_ / \_\_\_ / \_\_\_. (May not exceed 12 months from the date of signature below.)

I, \_\_\_\_\_, have had full opportunity to read and consider the content of this authorization form. I understand that, by signing this form, I am confirming my authorization that Dominion Dental Services, Inc. and Dominion Dental Services USA, Inc. may use and / or disclose my protected health information to the person or entity named on this form for the purpose described above. I understand this authorization is voluntary and confirms my consent to the described activity. I understand that I have the right to revoke this authorization at any time. I understand that revocation of this authorization will not apply to information that has already been released in response to this authorization. I understand that if I revoke this authorization, I must do so in writing and present my revocation to the following entity: Dominion Dental Services, Inc; Attention: Privacy Officer; 115 South Union Street, Suite 300; Alexandria, Virginia 22314.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a person other than the Member signs this form, please complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to the Individual: \_\_\_\_\_

Please return this completed authorization, or direct any questions regarding the form, to the following individual:

**Privacy Officer**  
Dominion Dental Services, Inc.  
115 South Union Street, Suite 300, Alexandria, Virginia 22314  
(703) 518-5000  
Privacycoordinator@dominiondental.com